"IN HUNGER I AM KING"—UNDERSTANDING ANOREXIA NERVOSA FROM A PSYCHOANALYTIC PERSPECTIVE: THEORETICAL AND CLINICAL IMPLICATIONS

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ABSTRACT: "In hunger I am king" (Kazantzakis, 1963) expresses the inner struggle of the anorectic. In the relentless pursuit of thinness, anorexia nervosa is a desperate search for autonomy and a self-respecting identity.

The syndrome is a serious emotional disturbance causing mental, emotional, and physical deterioration. Medical complications, such as cardiac arrest, can be fatal.

After addressing the development of anorexia as a clinical entity, the anorexia nervosa syndrome is examined from the divergent psychoanalytic theories and treatment philosophies of Freud’s Drive-Conflict Model, Ego Psychology, Interpersonal Theory, Object Relations Theory, Self Psychology, and Attachment Theory. Case material is presented to highlight the different psychoanalytic formulations.

INTRODUCTION

Kazantzakis, in his Essays on Spain, reports his meeting with a Spanish youth:

"That’s Manola," my Spanish friend laughed as he told me.

"All day long he lies there stretched out in the sun. He doesn’t work, even if it means he has to die of hunger."

I went up to him.

"Ah, Manola," I called to him. "They tell me you’re hungry. Why don’t you get up and work? Aren’t you ashamed of yourself?" Manola stirred sluggishly, then raised his hand with kingly grandeur. "En la hambre mando yo," he answered me. "In hunger I am king." As
though hunger were some boundless kingdom, and so long as Manola remained hungry, he kept the scepter of his kingdom in his own hands (Kazantzakis, 1963, pp. 252 - 253).

Conceived by Nemiah (1972) as a psychosomatic and developmental syndrome linked with particular psychopathologies and characterological styles, anorexia nervosa, “the starving disease,” is characterized by dramatic weight loss of 20-25% of normal body weight, an intense fear of becoming obese, a disturbance of body image, a refusal to maintain body weight over a minimal normal weight for age and height, and no known physical illness that would account for the weight loss (DSM-III-R, American Psychiatric Association, 1987).

The essence of the inner struggle in anorexia nervosa is expressed by Manola in this line, “In hunger I am King.” Anorectics, like Manola, feel enslaved and exploited. There is a discontent which seems to arise from a number of restrictions which were imposed upon self-development early in childhood and which, now, at the time of puberty, have become directed against the body self which anorectics sense is beyond their immediate control. In the “relentless pursuit of thinness”, anorexia nervosa is a desperate struggle for a “self-respecting identity” (Bruch, 1973).

This is a misleading term because anorexia nervosa literally means “nervous loss of appetite.” However, there is only the denial of appetite and hunger—not a lack of hunger and desire for food (Sours, 1980). Recovered anorectics report they are constantly hungry and obsessed with food. They can spend hours reading recipes and preparing gourmet meals. While these obsessive compulsive rituals protect the anorectic from overeating, much of the behavior (e.g., irritability, obsession with food, spaciness, difficulty concentrating, and hallucinations) are similar to that of starving people in general (Keys, Brozek, Henschel, Mickelsen, & Taylor, 1950; Casper & Davis, 1977).

The majority of anorectic patients are female, although 5 to 10 percent of cases diagnosed are males. Anorexia usually begins in adolescence, but its onset can occur well into adulthood. About 25% of anorectics will alternate their self-imposed starvation with episodes of binge-eating and self-induced vomiting. In this way, they are able to give in to their yearning for food without the fear of gaining weight (Garfinkel & Garner, 1982).

Anorexia nervosa is an illness of frightening physical characteristics. Anorectics exist on roughly 400 calories a day. If the starvation continues, they become walking skeletons with broomstick extremities and the pubic bone becomes the most protruding part of the body (Sours, 1980). Medical complications such as cardiac arrest, kidney failure, and
malnourishment can be fatal. Sours (1980) reported that the mortality rate varies from 2% to 15%, depending on the severity of the illness and the commitment to and effectiveness of treatment. Anorexia nervosa has a higher mortality than any other psychiatric disorder and because of this clinicians are reluctant to treat people who suffer from this syndrome.

Anorexia nervosa is a serious psychological disturbance causing mental, emotional, and physical deterioration. Anorectics are not able to think clearly and cannot accurately perceive reality. The disorder causes emotional fluctuations between states of euphoria and periods of despair, loneliness, self-loathing, and feelings of utter worthlessness.

Binswanger’s (1944) report of The Case of Ellen West represents a sensitive detailed account of the inner experiences of a patient suffering from this disorder. There are references to Ellen’s struggle for an independent identity. He cites his patient:

I am twenty-one years old and am supposed to be silent and grin like a puppet. I am no puppet. I am a human being, with red blood and a woman with quivering heart.... No, no, I am not talking claptrap. I am not thinking of the liberation of the soul; I mean the real, tangible liberation of the people from the chains of their oppressors. Shall I express it still more clearly? I want a revolution, a great uprising to spread over the entire world and overthrow the whole social order (p. 243).

There are also many references in Ellen West to the extreme isolation and loneliness of the anorectic: “I feel myself excluded from all real life. I am quite isolated. I sit in a glass ball. I see people through a glass wall, their voices come to me muffled. I have an unutterable longing to get to them. I scream, but they do not hear me. I stretch out my arms toward them, but my hands merely beat against the walls of my glass ball” (p. 256).

Anorexia nervosa is a complex illness and the assumed causes reflect the interaction of neurophysiological predisposition (Mecklenburg, Loriaux, Thompson, Anderson, & Lipsett, 1974), psychodynamics (Hogan, 1983; Wilson, 1983), family conflict (Minuchin, Rosman, & Baker, 1978), and social factors (Bruch, 1985; Palazzoli, 1978). It is not always possible to keep these separate as they often work in close interaction with each other. While the problems of anorexia are existential, that is, related to being in the world (Macleod, 1982), the problems of anorectics lie deep in their inner world. Psychiatric theory offers the most comprehensive framework to understand the spectrum of eating-related symptoms among psychiatric patients (Johnson & Conners, 1987).

This paper is written for the practicing clinician who wants to un-
derstand and implement a psychoanalytic approach in the treatment of anorexia nervosa. I first present an overview of the historical development of anorexia nervosa as a clinical entity, then examine the anorexia nervosa syndrome from the divergent psychoanalytic theories and treatment philosophies of Freud's Drive-Conflict Model, Ego Psychology, Interpersonal Theory, Object Relations Theory, Self-psychology, and Attachment Theory. Case material will highlight the different psychoanalytic formulations.

THE DEVELOPMENT OF ANOREXIA NERVOSA AS A CLINICAL ENTITY

Richard Morton (1889), a 17th-Century English physician is credited with the earliest report in the medical literature with the publication in London of his Treatise of Consumption. This was the first effort toward differentiating anorexia nervosa from tuberculosis. He called the condition "a nervous consumption" to refer to the physical condition of the seventeen-year-old daughter of Mr. Duke in St. Mary Axe. In vivid terms he wrote:

I do not remember that I did ever in all my practice see one, that was conversant with the Living so much wasted with the greatest degree of a Consumption (like a Skeleton only clad with Skin) yet there was no Fever but on the contrary a coldness of the whole body . . . only her Appetite was diminished, and her Digestion uneasie, with Fainting Fits, which did frequently return upon her (pp. 8-9).

Anorexia nervosa became a clinical entity with the independent reports by Gull (1868) in England and Lasègue (1873) in France in the 19th Century. Gull's concept was psychophysiological. He attributed the pathological changes to a "morbid brain force," a non-specific kind of energy which can transform whatever arises in the brain into somatic conditions in other organs. He attributed the want of appetite to "a morbid mental state" and commented that the treatment is like that of patients with "unsound mind." In contrast to Gull who tries to explain the disturbance on the basis of a disturbed nerve force, Lasègue, a French physician, was impressed with the psychological factors in the control of appetite. He postulated an active reaction on the part of the patient to food leading to disgust as the beginning of the illness. The anorexia is psychogenically motivated. Finding the illness resistant to the classical procedures of treatment, Lasègue (1873) commented, "Woe to the physician who, misunderstanding the peril, treats as a fancy without object or duration an obstinacy which he hopes to vanquish by medicines,
friendly advice, or by the still more defective resource, intimidation” (p. 146).

Until the early part of this century, it had been generally accepted
that psychological factors were the cause of anorexia nervosa. In 1895,
Freud noted that anorexia was related to melancholy and seemed to
occur in sexually underdeveloped girls (Freud, 1954). He wrote:

The neurosis concerned with eating, parallel to melancholia, is an-
orexia. The famous anorexia nervosa of young girls seems to me (on
careful observation) to be a melancholia where sexuality is unde-
veloped. The patient asserted that she had not eaten, simply because
she had no appetite, and for no other reason. Loss of appetite—in
sexual terms, loss of libido (p. 99).

A few years later, his study of the adolescent, Dora, who had a loss
of appetite after her encounter with Herr K., led him to a similar con-
clusion (1905).

The origin of anorexia became confused, however, when Simmonds
(1914), a pathologist, while performing an autopsy on an emaciated
woman, reported finding lesions in the anterior lobe of the pituitary
gland. Consequently, for the next several years, malnutrition was seen
as an endocrine disturbance, resulting in increased vagueness concern-
ing what was included in the anorexia nervosa concept.

It was not until 1930 that anorexia nervosa was distinguished as a
psychological entity and the psychodynamic conceptualization of an-
orexia nervosa has paralleled the development of psychoanalytic
thought (Kernberg, 1980).

ANOREXIA NERVOSA: A PSYCHOANALYTIC POINT OF VIEW

Drive—Conflict Model

The earliest psychoanalytic explanations of the anorexia nervosa
syndrome dealt mainly with the chief symptom, the “oral” component of
the disturbance and its symbolic significance. The syndrome was under-
stood as a defensive adaptation to highly insti-ntualized oral uncon-
scious fantasies (Lorande, 1943; Masserman, 1941; Moulton, 1942;
Thoma, 1967). Waller, Kaufman, and Deutsch (1940) epitomized this
explanation and felt that the anorectic syndrome was the rejection of
the wish to be orally impregnated by the father. They noted, “The role of
the fantasy of oral impregnation in our patients is quite clear with the
mouth as the receptive organ of food symbolizing conception, the gastro-
intestinal tract symbolizing the womb and the cessation of menstruation
being associated with pregnancy” (p. 272). Their views are expressed in
the following case illustration:
E. G. was a nineteen-year-old salesgirl. . . . Her weight had dropped from 118 to 87 pounds. . . . She complained of loss of appetite and a great aversion to food. . . . She gave a history of constipation dating back to childhood and this she gave as one of the reasons for the lack of appetite. She complained of weakness and irritability, with an intensification of quarreling with her parents. . . .

At the age of fifteen, since her menses had not yet appeared, oral endocrine therapy was resorted to and was followed by two scanty periods, one month apart. . . . Since that time she had had no menses.

. . . sexual activity was divorced from any knowledge of procreation, since the patient believed that procreation and pregnancy were . . . brought about by the acts of kissing and eating. At the age of twelve, the patient . . . became aware of the relation between genital sexuality and pregnancy. . . . Until that time, she had thought that a child was a natural result of marriage. A neighbor had told her that intercourse was necessary for pregnancy and that all people practiced it. . . . The thought that her own parents indulged in sexual intercourse disgusted her. About a year before admission to the hospital, the patient was introduced to a man eleven years her senior, whose economic status was secure. . . . Finally, some four months after the meeting, they were engaged to be married. One month after the engagement her fiancé attempted sexual intercourse with her . . . she reacted with a feeling of nausea which has reoccurred every time the episode was recalled. After the engagement the patient’s aversion to eating gradually began. This was not so much a lack of appetite as a distinct repulsion to food. Although her parents constantly emphasized the fact that her fiancée “would make such a good husband,” she was exceedingly repelled by him, particularly because he reminded her so much of her father (Waller et al., pp. 264 - 270).

_Ego Psychological Model_

The ego psychological model challenged the oral impregnation theory and emphasized the role of ego weakness in the anorectic patient (Eissler, 1943). Meyer and Weinroth (1957) viewed the essential conflict in anorexia to be preoedipal and shifted the focus of interpretation of phantasies of oral impregnation from a wish to be impregnated by the father to a wish for the re-establishment of mother-child unity. They saw the entire nursing experience to be a source of conflict and confusion. From mother-child observations, children of overly anxious mothers had a history of very early feeding disturbances. They postulated “an exceedingly early disordered relationship between child and mother which establishes the intensely oral stamp of these patients and their gradually unfolding symptomatology” (Meyer & Weinroth, p. 395).

Meyer and Weinroth noted that a psychotic ego organization underlies the obsessional behavior in anorexia nervosa.
Case Illustration

M. S., a 31-year-old married woman was admitted to the Psychiatric Service of The Mount Sinai Hospital . . . for the treatment of a profound anorexia and weight loss occurring during the preceding 8 or 9 months. . . . accompanied by states of depression, exclusiveness, and withdrawal. . . .

The mother, a restless, unhappy woman, unstable, narcissistic, and somewhat masculine in appearance . . . was already stricken with pulmonary tuberculosis when the patient was an infant. When the latter was 2 or 3 she was sent away from home for a while because she was too great a burden for her ailing mother. The father, described by the patient as an "icicle" . . . was generally distant.

Eating, . . . was "bad," particularly the eating of meat which she likened to "dead animals rotting inside of me. . . ." The word "breast," . . . was so repellent that she could barely force herself to pronounce it . . . Her condition deteriorated rapidly to a state of apathy, hopelessness, depression, and utter dependency. During this phase, 1 month after discharge from the hospital, she dreamed of a month-old baby who was being forced to feed himself with a spoon, a situation which aroused her indignation (Meyer & Weinroth, pp. 389-391).

Interpersonal Theory

The interpersonal theory of Bruch (1973, 1978) supplanted the earlier models and emphasized that the anorectic has major ego deficiencies resulting from chronically disturbed mother-child interactions. Having worked with anorexia nervosa for several decades, Bruch came to the conclusion that non-eating and associated weight loss were late features, secondary to underlying personal disturbances. Bruch (1973) isolated three areas of disordered psychological functioning. These are:

(1) A disturbance in body image characterized by delusional thinking so profound as to lead to a total denial of their emaciated appearance, (2) A disturbance in the ability to perceive and identify body stimuli, and (3) A paralyzing sense of ineffectiveness pervades their lives. . . . Eating is not an action performed by themselves but rather something which happens to them—an act over which they have no control (pp. 251-253).

Bruch (1973) reported that the experience of hunger is not innate, but something that contains appropriate elements to learning. Bruch argues that the key to the feeding experience is whether the response to the infant's need was appropriate or was superimposed according to what the mother felt was needed, often in error.

The case study of Gail (Bruch, 1973) expressed with startling and dramatic directness the crucial issues of many patients with anorexia nervosa, namely, the basic delusion of not having an identity of their own, of not even owning their body and its sensations, with specific inability of recognizing hunger as a sign of nutritional need. Bruch wrote:
She entered the New York State Psychiatric Institute in October, 1959, at the age of 20. . . . Her weight was 96 lbs, a sacred figure to which she had rigidly clung for the past 4 or 5 years . . . .

Her absolute insistence on remaining at this magic weight of 96 lbs led to her dominating the household with enforced rituals. Her parents were forced to shop three times a day because she would not permit food in the home between meals . . . .

Her behavior was so violent that within two months her parents moved out into a furnished room, the address of which they kept a secret . . . . In fits of anger Gall had carved initials into the furniture, and the bedroom door was covered with hammer marks made when Gall had tried to invade her parents' room after they had locked themselves in desperation . . . .

In reviewing the previous treatment approaches . . . the underlying conceptual delusions about herself, and all human relatedness had not been recognized and therefore had remained unexplored and uncorrected . . . . "I tried to remake my parents all through my life. I wanted to put them in a different role, make them warm and understanding so that they could raise me better. It is their fault that I am not a good child. What I am now, my parents have created. I am the product of their creation . . . ." Being thin was one way of being something in her own right, not quite her parents' product . . . . They had always pushed food on her and wanted her to be fat . . . .

The daughter, conceived of as her parents' creation, had turned monster-like against her creators . . . . not in aggression but in a desperate effort to change her parents so that they would undo their errors and recreate her in a better mold. The deep conviction of her own helplessness was vividly acted out in the dieting arrangement, which in turn must be conceived of as a consequence of her inability to recognize correctly hunger or satiation; hence, the urgency with which she demanded control over her own bodily needs through the parents (pp. 47–50).

Object Relations Theories

The object relations model has supplanted Bruch's purely interpersonal approach to the ego defect in anorexia by elaborating on the distortions of the underlying self and object representational structures. Recent authors (Palazzoli, 1978; Masterson, 1977, 1978; Johnson & Conners, 1987) have focused upon the symbiotic-like attachments anorectic patients have with their parents and the incompleteness of the separation-individuation process. Mahler, Pine, and Bergman (1975) referred to this process as the psychological birth of the individual. They saw separation-individuation as an intrapsychic process, a psychological achievement in . . . . "the establishment of a sense of separateness from, and relation to, a world of reality, particularly with regard to the experiences of one's own body and to the principal representative of the world as the infant experiences it, the primary love object" (p. 3).

Using an object relations schema, Palazzoli (1978) has hypothesized
that, in an attempt to separate and individuate from a sadistic "bad introject" which becomes fused with the body self, the adolescent ruthlessly controls her own body to the point of self-starvation. Palazzoli (1978) wrote, "The body is experienced as having all the features of the primary object as it was perceived in a situation of oral helplessness; all-powerful, indestructible, self-sufficient, growing and threatening" (pp. 86-87).

As one of her patients, Rita, put it, "I have never been left to experience things in my own way. This is the worst loss anyone can suffer. It leads to emptiness, to a lack of emotional contact with life, to a lack of vitality, of whatever makes you feel yourself instead of a heavy shapeless thing" (Palazzoli, 1978, pp. 86 - 87).

Masterson (1977) viewed the symptoms of anorexia nervosa as a defense against a deep abandonment depression that would emerge if separation-individuation was attempted. Adapting the Mahlerian schema, he has reframed the problem of anorexia in terms of the borderline phenomena (e.g., early developmental failure which results from chronically disturbed mother-child interactions during the rapprochement phase of separation-individuation). For Masterson, the mother of the anorectic patient usually suffers from a borderline syndrome herself. Having been unable to separate from her own mother, she fosters continuity of the symbiotic union with her child, encouraging dependency to maintain her own emotional equilibrium. Therefore, she discourages moves toward separation-individuation by withdrawing her support.

Masterson (1978) stated that the anorectic is haunted by both positive and negative introjects. The positive, supportive, rewarding, maternal introject is in response to the anorectic's dependent clinging behavior. The hostile, negative, rejecting, withdrawing, maternal introject is in response to the anorexic's attempt at separation.

According to Johnson and Conners (1987), the key feature of borderline anorectics is that they have experienced parental overinvolvement as malevolently intrusive. They perceive that their efforts to separate or differentiate will result in active punishment or retaliation. Consequently, they develop an elaborate paranoid defense in which fat becomes the symbolic focus to protect them from intrusiveness that is experienced as malevolent. The distortion of body image allows a psychological organization to exist, which gives the patients autonomy, control, and a sense of purpose and motivation. They highlight their ideas in the case of Rita:

Twenty-year-old Rita was brought to treatment by her mother. At the time of the consultation, she was five feet seven inches tall and weighed ninety-two pounds, had been amenorrheic for five years, and insisted that nothing was wrong with her.
Rita experienced her mother as overwhelmed, needy, angry, hypercritical, intrusive, and vindictive. . . . She recalled how her mother would rummage through her personal items in her room and listen in on phone conversations. . . . When Rita began to starve herself, her mother became increasingly intrusive by demanding information concerning food intake and bodily functioning. At one point Rita protested that it was her body and she would treat it as she pleased. This provoked a tirade from her mother where she screamed that Rita’s body was her body; she had given her the body and what Rita did to her body she was doing to her.

Rita established fat as a paranoid object and mobilized her life to defend against any malevolent invasion by it. Fat had essentially become a concrete manifestation of the maternal intrusiveness. It was something that she could control. Importantly, thinness for Rita was not an aesthetically pleasing experience or a competitive achievement. She was not exhibitionistic about her thinness. Instead it offered a sense of safety (Johnson & Conners, 1987, pp. 108-109).

A Self-Psychological Perspective

According to self psychology, the internalization of certain mental functions such as the capacity to provide one’s own sense of security and comfort, self-esteem, and tension regulation are crucial if the individual is to develop the capacity to tolerate separation without some degree of psychic fragmentation. An important concept of self psychology is that of “selfobject” (Kohut, 1971), defined as an object that is experienced as a part of the self, but is cognitively perceived as external to the self, similar to Winnicott’s (1953) “transitional object.”

Kohut (1971) and Goodstein (1985) referred to the importance of “selfobject” parenting which must empathically mirror the child’s grandiosity and allow for the idealization of the parental selfobject figures so that the “child’s archaic grandiosity and idealization are converted into a cohesive self with good self-esteem and healthy goals and ideals” (Goodstein, 1985, p. 62). An absence of empathic selfobject responsiveness is likely to interfere in the internalization process and a disorder of the self may result.

Self psychologists see anorexia nervosa as a disorder of the self as well as a disorder of separation-individuation. Anorectic patients have experienced a lack of adequate and responsive selfobject parenting. Consequently, their internalization process has gone awry. Deficient in self-regulatory structure, they are ill equipped to separate. Anorectics lack reliable self-soothing, mood, and tension regulation, and, consequently, they remain dependent upon selfobjects for their well being (Goodstein, 1977). Starving anorectics devote themselves to the care and feeding of others to deny their own selfobject needs.

Alan Goodstein (1985) examined anorexia nervosa from a self-psychological perspective. He sees the symptoms of anorexia to represent “both a disruption of the self and the defensive adaptive measures against
further disruptions" (p. 55). Because anorectics suffer from fragile self esteem, and seem to be disconnected from themselves and their core feelings, Goodsit sees anorexia nervosa as a “theory of deficit phenomena” (p. 56) modeled after Kohut’s (1971) self theory.

The following is a case illustration from my practice:

Mary, a twenty-five-year-old, single woman, reported having been anorectic for the past eight years. At the time of the initial consultation, she expressed deep feelings of shame and humiliation for needing treatment. Initially, Mary seemed more interested in my well-being than in unveiling her difficulties. Over time, she revealed she was an only child. When she was five-years-old, her mother was stricken with multiple sclerosis which gradually left her debilitated. Mary described her father as a cold, detached man, who was over burdened with running the family business. Progressively, Mary assumed the role of the “adult caretaker.” At age eight, she was responsible for the marketing, laundry, and other household chores. Needless to say, she was regarded by her mother as “an angel sent from heaven.” Mary enjoyed the approval for her caretaking behaviors. However, she talked about a frightened, lonely little girl, who would retreat to her room and talk to an imaginary “Mr. Owl,” which provided the comfort and soothing she lacked from her parents.

Mary’s anorexia developed after she graduated from high school and was faced with the prospect of going away to college. Having been denied her own selfobject needs by devoting her childhood to the physical and emotional care of her mother, Mary lacked reliable internal self-regulation and was ill-equipped to separate. Her illness served a dual function. Her self-imposed starvation afforded her the experience of gaining some autonomy and control over her life. Also, the attention over her emaciation raised concern about her ability to separate and to attend an out-of-state college and she remained at home. Thus, Mary was protected from her terror of moving out into the world and of being on her own.

ATTACHMENT THEORY

“The struggle to understand the infant-mother bond ranks as one of the great quests of modern psychology” (Karen, 1990, p. 35). The capacity of the individual to make a bond with main attachment figures is fundamental to emotional security. All later relationships are based on a generalization of this early mother-child bond (Ainsworth, 1972).

The concept of attachment was introduced by John Bowlby as part of his attempt to reformulate theory about the origins of the child’s tie to his or her mother (Bowlby, 1958). The key point for Bowlby (1973, 1979) is the strong causal relationship between our experiences with our parents and the later capacity to make affectional bonds. The availability and responsiveness of the attachment figure (Bowlby, 1973, 1979; McMilien, 1992) is crucial in helping the child to develop the sense of security that is needed to begin to develop the capacity to rely trustingly on others (Bowlby, 1979). Bowlby (1979) has suggested a relationship
between the disruption of affectional bonding during childhood, the impairment of the capacity for affectional bonding, and the psychological problems that individuals develop.

From an attachment perspective, anorexia nervosa is viewed as a disorder of disrupted early childhood attachments. Consequently, anorectics have been denied the sense of security, trust, and confidence needed to separate from their primary caretakers and explore the world. The over-controlling or under-nurturing mothering leads the anorectic patient to stress proximity in interpersonal contacts (Minuchin, 1978). The mothers of anorectics appear to have encouraged symbiotic-like attachments, discouraging the separation-individuation process among anorectic patients. Some foster dependency while others fail to foster autonomy through their inability to provide an adequate and secure home base from which to separate (Sours, 1974).

Henderson (1974) placed anorexia nervosa in the category of “care-eliciting” syndromes. These disorders tend to occur when an individual perceives himself or herself to be receiving insufficient caring behavior from others. Henderson defined “care-eliciting,” which he regards as an essential part of the phenomenon of attachment, as a pattern of activity on the part of one individual which evokes from another responses which give comfort. The latter may take many forms, such as: providing close body contact, or, at a more complex level, the expression of concern, esteem, or affection through language. In abnormal care-eliciting, there is an intensification of what are ordinarily considered to be signals within the normal range of care-eliciting behaviors, such as crying, clinging, or other verbal appeals. These signals cause distress to the individual and to others, but their consequence is developmentally ancient: they bring important others closer.

Henderson views the refusal to eat and the subsequent emaciation of anorectic patients as two powerful signals to evoke anxiety and concern in their parents. As a consequence, there is much expression of solicitude, which serves to reinforce the symptoms. According to Henderson, the syndrome of anorexia nervosa may conceivably be attributed to the patients acquiring less injurious ways of obtaining attachment.

While some authors have attempted to integrate Bowlby’s concepts of attachment with the onset of anorexia nervosa (Henderson, 1974; Sours, 1974; Minuchin, 1978; Crisp, 1981; Chattoor, Schaefer, & Dickson, 1984), research linking anorexia nervosa to attachment is scant (Gibbs, 1989; Helinski, 1984; Armstrong & Roth, 1989).

The author (Chassler, 1993) has empirically linked the onset of anorexia nervosa to early problems of attachment with significant caretakers. Specifically, the anorectics in the study relative to controls experienced their early attachment figures as significantly more unresponsive, unavailable, and untrustworthy. The anorectic subjects re-
ported having been subjected to repeated threats of separation in the form of parental arguing, feeling responsible for their parents safety and/or happiness, and of being abandoned, either by being sent away or of being left by their parents. Thus, anorectics in their early development have been faced with repeated threats of separation. This has caused uncertainty concerning their sense of security, which has resulted in constant feelings of abandonment, depression, and helplessness. Peer relationships were significantly affected. In childhood, the anorectics reported poorer peer support systems, fewer friends, and more difficulty making friends than did the controls.

The following quote is typical of many of the respondents from the current study: I realize that I have a strong desire to be attached to someone in my life at all times, yet, I could never keep the same person in my life for any length of time. I can remember thinking what I felt like growing up and the one thing that sticks out is the sense of not feeling an affectional bond with anyone in my life. I believe that I did not have a secure base growing up and, consequently, I had some difficulties maintaining any close relationships. I have become aware of how I relate to my present relationships with the same feelings of abandonment that I felt with my parents. I would always pick friends whom I could take care of and who needed my help. These continuously strong yet weak relationships I had with people allowed me to feel safe and in control (Chassler, 1993).

TREATING ANOREXIA NERVOSA

_Treatment of Anorexia Nervosa from a Psychoanalytic Perspective_

Classical psychoanalysis has provided the model for the psychotherapeutic approach, but its application to working with anorectics has changed. The scope of psychoanalysis has been enlarged to include a population of people who suffer from disorders of the self, of attachment, and disorders of ego development.

The initial psychoanalytic focus was an id analysis of the anorectic's wishes and fears of oral impregnation. Results were unfavorable and in some way, this method re-exposed the anorectic to feelings of impingement (Winnicott, 1965); that is, of being told what to think and feel which confirmed his or her sense of inadequacy.

Bruch (1973), instead of searching for the underlying unconscious conflicts, has shifted her focus to help anorectic patients in developing a sense of competence and effectiveness in dealing with their daily problems of living. Through Bruch's noninterpretative "fact-finding" approach and "constructive use of ignorance," she helps her anorectic patients to reconstruct the real or fantasized difficulties and emotional stresses that led to their eating disorder. Important to Bruch is the pa-
tient’s “active participation in the inquiry” which leads to a clarification of their cognitive distortions and helps anorectic patients rely on their own thinking.

From an object-relations perspective, Masterson (1976) suggested that the therapist has to be a real person who supports eating-disordered patients with their struggle to separate and individuate. At the same time, the therapist has to help them resolve the early abandonment depression associated with the original separation-individuation phase of development.

The treatment of anorexia nervosa for the self psychologist requires the therapist to function as a selfobject (Goodsitt, 1985). The primary focus of the therapeutic activity is the therapist actively filling in the deficits in the patient's self. Acting as a selfobject, the therapist provides internal tension regulation by actively reassuring and calming the patient. For example, if the anorectic patient is panicky about rapid weight gain, the therapist provides reassuring knowledge about the metabolic process.

It is important for the therapist, acting as selfobject, to tolerate the idealization and not disabuse the patient of his or her illusions prematurely (Kohut, 1971). The well-being of the self-organization is enhanced when the therapist allows idealization or provides mirroring of the patient’s grandiosity.

From an attachment perspective, the transference provides anorectic patients the opportunity to sort out their deviant patterns of attachment. Bowlby (1979) emphasized the genuine relationship between the therapist and the patient that must develop if progress is to be expected. Similarly, Sable (1983, 1992) noted that the support of the therapeutic bond is central to change and the transference is perceived as providing an atmosphere in which to experience a temporary attachment relationship.

The therapist who listens empathically will be internalized as a constant, reliable attachment figure, one that has been experienced as accessible and responsive, having provided support, comfort, and protection. This new attachment relationship becomes the foundation for anorectics to update their early-disturbed attachment experiences so that they can move out and explore the world with confidence and security.

DISCUSSION

The divergent psychoanalytic theories view anorexia nervosa as a defensive adaptation to chronic disruptions of normal human development. In this context, anorectics are seen suffering from an illness, a
form of pathology, that results from early childhood developmental failures.

It is the opinion of this author that the non-eating of anorectics expresses not only an illness caused by deep-rooted childhood conflicts and developmental failures, but also, the hope to repair their unfulfilled needs with important early attachment figures so that they experience the security, comfort, trust, and confidence to rely trustingly on others and on themselves. Case "ment (1975, 1990, 1991) described that "... there may be an unconscious search (or hope) for what is needed to meet unmet needs; and that parents and analysts are given clues to what is needed in behavior, and even in some forms of defense or pathology" (p. 293). In my view, for starving anorectics, the "care-eliciting" behaviors (Henderson, 1974) that non-eating elicits from significant others, is an expression of their unconscious hope to repair the original caretaking experience so that they may develop the sense of security and confidence to move along the normal path toward growth and self reliance.

Regardless of the clinician's psychoanalytic orientation in working with starving anorectic patients, only when a solid therapeutic alliance has been established, which takes a substantial period of time, can the interpretative work begin. Typically, these patients are reluctant to start treatment. Initially, anorectics take delight in their emaciated appearance. Moreover, the separation and attachment difficulties that anorectics have experienced, in terms of their fears of being abandoned, unwanted, and unloved, complicate the forging of a healthy therapeutic alliance with someone they trust will be caring and reliable. The anorectic patient usually exhibits hostile, distant, and certainly cautious attachment (Chassler, 1992), and is extremely mistrustful of the therapist. Representative of the literature, Johnson and Conners (1987) described the primary transference themes revolving around "... whether the patient is capable of being loved and whether the therapist is committed, durable, and able to help her contain and organize her thoughts and behaviors" (p. 111).

The transference becomes the playground (Freud, 1914; Sanville, 1991) in which anorectic patients are able to re-experience their struggles against passivity, and to strive for a balance between autonomy and attachment.

Through the analysis of the transference, starving anorectics are able to gain insight into their ambivalence toward the maternal object (Sours, 1980), as well as other significant early attachment figures. They then attempt to separate the therapist, as well as other objects, from the early primary caretakers, in the long term replacing an old "model" by a new one (Bowlby, 1980).

The anorectic patient in the transference has a new object or attach-
ment experience and over time, through the mechanism of introjection and identification, new intrapsychic structures form, related to whole object relations (Sours, 1980).

CONCLUDING COMMENTS

Prolonged starvation mars the psychological functioning of the anorectic and there has to be some degree of nutritional restitution before effective therapeutic work can begin (Bruch, 1973). Any treatment plan for anorexia nervosa must be based on a careful evaluation of the patient's medical and metabolic status, along with a diagnostic and dynamic-structural formulation of the patient's disturbance (Silverman, 1977).

Anorexia nervosa is a puzzling and disturbing syndrome and prognosis for recovery, based on the evaluation of the literature, is confusing. There are no controlled studies of the outcome of treatment for the anorectic patient. Successful therapy is often reported only in terms of weight change, which, according to Bruch (1973), is misleading. Effective treatment not only depends on weight change, but on the therapist's capacity to understand the basic underlying psychological struggles of anorectics in order to help them bring about a change in their personality.

Crisp (1981) suggested that long term outpatient psychotherapy is important to help the anorectic patient. He stated, "It is important to construe her destiny in terms of other than her body shape. If this does not begin to happen then it is unlikely that the anorectic can indefinitely sustain a mature body weight in the face of her continued panic and preoccupations" (p. 234).

My own experience in working with the anorectic patient is best summed up by Bruch, (1985) who wrote, "Working with these youngsters in their desperate search for selfhood and value is difficult and often frustrating. I have found it also deeply rewarding. Basically, it amounts to helping youngsters to discover their creative and human potential, and to give up the hateful, unlovable, empty, and defective self-image that underlies the illness" (p. 18).

REFERENCES


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